

MEDICAL HISTORY

Patient Name:

Birth Date:

Date Created:

General

Who is your primary care physician?

☐ Yes ☐ No

If yes

How would you rate your general health?

☐ Excellent☐ Good☐ Fair☐ Poor

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

☐ Yes ☐ No

If yes

Are you on a special diet?

☐ Yes ☐ No

If yes

Do you use any controlled substances?

☐ Yes ☐ No

If yes

Do you use tobacco or nicotine?

☐ Yes ☐ No

If yes

Do you smoke or vape?

☐ Yes ☐ No

Do you frequently get cold sores/fever blisters?

☐ Yes ☐ No**Women: Are you...**

Pregnant/Trying to get pregnant?

☐ Yes ☐ No

If yes

Nursing?

☐ Yes ☐ No

Taking oral contraceptives?

☐ Yes ☐ No**Allergies**

Are you allergic to any of the following?

☐ Aspirin☐ Codeine☐ Fluoride☐ Iodine☐ Local Anesthetics☐ Milk☐ Red Dye☐ Tetracyclin☐ Chlorhexidine (CHX)☐ Erythromycin☐ Fruit☐ Latex☐ Metals☐ Nuts☐ Sulfa

Other

☐

If yes

Please list any medications or vitamins you are taking, with dosages.

Medical History

Do you currently have, or ever had?

AIDS/HIV Positive

☐ Yes ☐ No

Artificial Heart Valve

☐ Yes ☐ No

Cancer

☐ Yes ☐ No

Digestive or Eating Disorders

☐ Yes ☐ No

Glaucoma

☐ Yes ☐ No

Heart Problems or Cardiac Stent

☐ Yes ☐ No

Infective Endocarditis

☐ Yes ☐ No

Neurologic Disorders

☐ Yes ☐ No

Psychiatric Treatment

☐ Yes ☐ No

Scarlet Fever

☐ Yes ☐ No

Sleep Disorders

☐ Yes ☐ No

Tonsillitis

☐ Yes ☐ No

Ulcers

☐ Yes ☐ No

ADD/ADHD

☐ Yes ☐ No

Arthritis or Gout

☐ Yes ☐ No

Chemotherapy

☐ Yes ☐ No

Drug Addiction

☐ Yes ☐ No

Heart Murmur

☐ Yes ☐ No

Hepatitis

☐ Yes ☐ No

Kidney Disease

☐ Yes ☐ No

Orthoedic or Soft Tissue Implant

☐ Yes ☐ No

Radiation Treatment

☐ Yes ☐ No

Seizures or Epilepsy

☐ Yes ☐ No

STI/STD/HPV

☐ Yes ☐ No

Trouble Hearing/Hearing Aid

☐ Yes ☐ No

Viral Infections

☐ Yes ☐ No

Anemia

☐ Yes ☐ No

Blood Disorder/Disease

☐ Yes ☐ No

Diabetes

☐ Yes ☐ No

Fainting Spells/Dizziness

☐ Yes ☐ No

Heart Pacemaker

☐ Yes ☐ No

High or Low Blood Pressure

☐ Yes ☐ No

Liver Disease or Jaundice

☐ Yes ☐ No

Osteoporosis/Osteopenia

☐ Yes ☐ No

Rheumatism

☐ Yes ☐ No

Shingles

☐ Yes ☐ No

Stroke

☐ Yes ☐ No

Thyroid Disease

☐ Yes ☐ No

Have you been diagnosed with Autism/Autism Spectrum Disorder?

☐ Yes ☐ No

If yes

Any additional Comments?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (o

Signature of Patient, Parent or Guardian:

X

Date: _____